

## Insulin and the Suicidal Patient

TO THE EDITOR: Insulin overdose as a method of attempted suicide, although not common, should be considered as a possibility when treating depressed diabetic patients.<sup>1</sup> We report two cases that illustrate some problems that can arise when a suicidal patient has access to insulin.

### Case 1

A 21-year-old woman without a previous history of either psychiatric or medical illness was admitted to hospital unresponsive with a serum glucose level of 22 mg per dl and a generalized seizure. Findings on physical examination were unremarkable except for initial horizontal nystagmus. She was treated with intravenous saline and glucose infusions and improved. Serum glucose determinations over the first 24 hours were of variable range (28 to 197 mg per dl) requiring vigorous medical treatment at times. Serum toxicology screen showed the presence of acetaminophen, ephedrine/pseudoephedrine hydrochloride, phenobarbital and phenytoin presumptively. Blood alcohol level was 221 mg per dl.

In psychiatric consultation carried out after medical stabilization, it was found that the patient had been dismissed from her job two months earlier for heavy alcohol intake. She was unable to find another job and for this reason felt life was worthless. She admitted to auditory hallucinations for the past five years and was hearing commands to kill herself. She took eight prefilled insulin syringes containing 12 units of regular and 30 units of NPH insulin from a diabetic friend and injected them into her temple believing that the insulin would reach her brain quickly and kill her. Additionally, she ingested other medication found in the medicine cabinet. She continued to express suicidal ideation and was transferred to a psychiatric hospital for further treatment.

### Case 2

A 41-year-old woman had a history of insulin-dependent diabetes mellitus, alcohol abuse and recurrent depression with multiple suicide attempts. These included overdose with pills and drinking household cleaner, and a recent attempt in which she locked herself in the trunk of her car, slashed her wrists and throat, and hit herself in the head with a tire iron. She had been treated in the past with antidepressants and electroconvulsive therapy. There was a family history of depression and her mother and sister both committed suicide by pill overdose with alcohol ingestion.

The patient was admitted to the medical service of the hospital for treatment of hypoglycemia with serum glucose determinations of 28 mg per dl and a generalized seizure. On physical examination there were no acute findings. The patient was treated with intravenously given saline and glucose infusions and improved. Serum glucose determinations over the first 48 hours in hospital were of variable range (20 to 258 mg per dl) requiring additional glucose infusions at times. Other test results were unremarkable and the patient was transferred to the psychiatric service because she had expressed suicidal ideas.

She admitted to injecting herself intravenously with "a couple of bottles" of NPH insulin in a suicide attempt. She had a poor appetite and did not adhere to diabetic dietary restrictions in the hospital although she was maintained on insulin. The patient had been admitted to hospital in the psy-

chiatric facility one month earlier for depression and at that time ate poorly while continuing to receive insulin. This led to multiple readjustments of the insulin dosage both during this hospital stay and previously, and numerous fasting serum glucose determinations were found to be below normal.

The patient was treated with electroconvulsive therapy and improved. She later became delusional, however, and again expressed suicidal ideations necessitating long-term treatment.

The preceding cases illustrate the difficulties that can arise when a suicidal patient has access to insulin. The education of the public to increase awareness of this problem might be indicated to prevent further episodes of a similar nature.

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## Conversation, the Ailing Humanity

TO THE EDITOR: While in the ward the other day, I observed a house officer at the bed of a new patient. The young physician sat far from the elderly gentleman and posed his questions with a loud voice and a peremptory tone. I knew he was trying to be efficient, to get to the point, but I also knew that he would never succeed in making the patient his willing interlocutor. Wondering how many "poor historians" are iatrogenically induced, I walked into a hospital meeting. As usual, coffee, statistics and strategies were served in abundance but there was no time—nor attempt—to foster an ounce of new benevolence among the participants. By then other experiences were coming to mind: attending parties with too many people sitting along the walls of the room, their plates overflowing with food, their curiosity and imagination untried; meeting medical school applicants who have astounding academic records but are not aware of where an older brother or sister is living.

One may question whether we are still willing and able to communicate with each other. Or are we so trapped in busy schedules and programmed behaviors that we forgo the exhilarating chance of knowing each other—and life through the soul of the other? The risk is real, and perhaps here more than in Europe, where the number of opportunities to share at least fragments of one's soul tends to be greater. I remember the outdoor markets, the squares, the cafés: drawing variegated crowds, providing time and place for observing and exploring, gathering and philosophizing. These daily physical opportunities have been kept and nurtured through the centuries, expressions of the spirit of the agora, of its commitment to foster a wealthy dialectic of interpersonal relationships which ensures that no person should remain stranger to the other.

Do these activities appear superfluous in our efficient,

productive environment? If I interpret correctly the success of bumper stickers, reiterating every day their silent messages of likes and loves through the long hours of commute, I shall argue that people do miss the opportunity to talk about themselves. But there is no time, not for talking, not for listening. One then wonders how fulfilling is our time otherwise spent, for what ultimate goal are we striving and competing. Is the goal to enhance the quality of life? How can we achieve it if we ignore each other's unique needs and hopes? These questions are relevant to our global social demeanor, as they are to our practice of medicine. Diagnosing and treating are restrictive technical synonyms for understanding and healing, whose chances to occur depend upon the full availability of the parties involved. One cannot heal unless one understands, and one cannot understand unless one explores. Nor can one be healed without being understood and, in order to be understood, one must find or be given the opportunity to recount one's self. Reciprocal comprehension and trust are engendered through friendly, unhurried conversations much more than through form-guided anamneses that have little subtlety for matters of the soul.

The problem may be that we are not taught much of the art of conversing. Watching television, playing computer games, technical reading and multiple-choice exams add very little to our dialectic capabilities. But if conversation glows in the artist, it thrives in the amateur. And amateur we can easily become by starting to cultivate the pleasure of discovering our neighbor, our relative, our patient. The first attempts at an unpracticed activity may be clumsy, even embarrassing, but after a while craftsmanship develops: the attitude, the tone of voice, the words almost elect themselves from among the many possible, and self-perpetuating ties are established. We should not miss such simple opportunities to add genuineness to the practice of medicine and benevolence to life around us.

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## Immune Complex Disease—Adult Still's Disease? Hepatitis B?

TO THE EDITOR: We have recently seen a patient with clinical and laboratory features consistent with adult Still's disease. Results of serologic testing during the course of illness, however, have raised a conundrum that we feel merits emphasis. We hope this case report will be a valuable addition to Dr Larson's review in the May issue.<sup>1</sup>

### Report of a Case

A 29-year-old previously healthy man presented with a four-day history of fever, pharyngitis, polyarthralgias and myalgias. He appeared acutely ill with a temperature, taken orally, of 39.9°C. A maculopapular rash was seen on the anterior thorax and proximal upper extremities. Bilateral synovitis of knees and elbows and hepatomegaly with scleral icterus were present. Initial laboratory tests showed anemia, leukocytosis, elevated liver function values, proteinuria and cylindruria. Antistreptolysin O, rheumatoid factor, antinuclear antibodies, cryoglobulins, complement profiles and multiple serologic tests were negative. Tests for hepatitis B surface antigen (HB<sub>s</sub>Ag) and anti-HB<sub>s</sub>Ag were negative. All

cultures showed no growth. Subsequently, pleuropericarditis with bibasilar rales, pedal edema, an S3 and a three-component rub developed. Splenomegaly was noted. Pharyngitis and rash were evanescent. An x-ray study of the chest showed a left lower lobe infiltrate with effusion and cardiomegaly. An echocardiogram confirmed a pericardial effusion. A 24-hour collection of urine showed 3.2 grams of protein. Open lung, kidney and bone marrow biopsies were carried out and findings were all nondiagnostic. The patient improved with corticosteroids. Repeat anti-HB<sub>s</sub>Ag and anti-HB<sub>c</sub>Ag studies were positive with negative HB<sub>s</sub>Ag. Circulating immune complexes were shown using the C1q-binding assay.

We feel this case satisfies the inclusion criteria of Medsger and Christy.<sup>2</sup> Had we not obtained repeat hepatitis B serologies, a diagnosis of adult Still's disease might have been established by exclusion. But is this diagnosis tenable despite positive hepatitis B serologies?

A case similar to ours has been reported,<sup>3</sup> in which adult Still's disease was described two months after HB<sub>s</sub>Ag-positive hepatitis, with serologies seven years later showing both anti-HB<sub>s</sub>Ag and anti-HB<sub>c</sub>Ag. In view of the variable temporal relationship between hepatitis B infection and related vasculitis,<sup>4</sup> we feel these two cases are compatible with immune complex disease due to hepatitis B.

Many etiologic agents, sharing a common mechanism of disease induction (immune complex formation) are bound, when conjoined with certain constitutional factors, to give rise to identical features. Whether one emphasizes descriptive aspects or putative mechanism of disease is, at our present level of understanding, a matter of personal choice. A diagnostic effort should not stop at the phenomenological level, though we agree with Dr Larson that adult Still's disease is a distinct clinical syndrome. How would he then classify the above two cases?

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### Dr Larson Replies

TO THE EDITOR: Drs Lang and Petrozzi report a very interesting case which illustrates one of many problems with the diagnosis of "adult Still's disease." Based on the clinical course and serologic findings, I would classify this patient as having vasculitis and immune complex disease due to hepatitis B. Although elevation of liver enzymes (aspartate aminotransferase and alanine aminotransferase) and acute and chronic hepatitis are seen in patients with adult Still's disease,<sup>1,2</sup> jaundice is not common<sup>1,3,4</sup> except in patients with fulminant hepatic failure or chronic liver disease.<sup>5,6</sup> Most important, although the case does meet the inclusion criteria